STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165296	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pleasant View Care Center	200 Shannon Drive Whiting, IA 51063

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44474 Based on clinical record review and staff interview the facility failed to develop Care Plans to address opioid medication and antidepressant medication side effects to watch for 1 out of 5 sampled residents reviewed for comprehensive Care Plans (Resident #13). The facility reported a census of 48 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] for Resident #13 documented diagnoses of heart failure, hypertension, and Non-Alzheimer's Dementia. The MDS showed a Brief Interview for Mental Status (BIMS) score of 8 indicating moderate cognitive impairment. Review of the March Medications Administration History Report revealed the following orders: a. Escitalopram (antidepressant medication) daily for depression with a start date of 1/23/24 b. Hydrocodone- acetaminophen (opioid medication) as needed for pain with a start date of 11/21/23. Review of the MDS dated [DATE] revealed the resident was taking antidepressant medication in the review period. Review of the signed Physician Order Report dated 2/23/24 with a signature date of 2/24/23 revealed the following orders: a. Hydrocodone-acetaminophen as needed for pain with a start date of 11/21/23 b. Escitalopram daily for depression with a start date of 1/23/24 Review of the Care Plan with a revision date of 2/10/24 lacked information regarding the side effects of antidepressant medication and opioid medication. Review of the facility provided policy titled Care Plan Procedure undated revealed the Care Plan will include but not limited to medications that include antidepressants and pain medications. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/06/24 at 12:53 p.m., with the Assistant Director of Nursing revealed the side effects should be listed on the Care Plan.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on staff interview, chart review, and staff education review, the facility failed to ensure that residents were safe from accidents and hazards for 1 of 3 residents (Resident #33). A Certified Nurse Aide (CNA) failed to apply a gait belt before attempting to transfer Resident #33 from the shower chair to the wheel chair and the resident fell to the floor. The facility reported a census of 48 residents. Findings include: According to the Minimum Data Set (MDS) dated [DATE], Resident #33 had a Brief Interview for Mental Status score (BIMS) of 8. She was at risk for falls and required extensive assistance with bathing. The Care Plan updated on 2/25/24, showed that Resident #33 was at risk for falling and had a history of falls. She was incontinent of bowel and bladder and was on 2 or more high fall risk drugs. She had impaired mobility and impaired cognition. A Nursing Note dated 1/09/2024 at 3:37 PM showed that Resident #33 fell in the shower room after getting a shower. The resident had stated that the floor was slippery and she fell . According to a Non-Pressure Skin Condition Report dated 1/9/24, the resident sustained a bruise on the top of her right hand that measured 10 centimeters (cm) x 8 cm. On 3/6/24 at 2:00 PM the Director of Nursing (DON) said they implemented an intervention after this fall to put a towel on the floor for the residents in the shower room after the bathes. She said that it was her understanding that the CNA used a gait belt when transferring the resident from the shower chair to the wheel chair. On 3/06/24 at 2:18 PM Staff C, Certified Nurse Aide (CNA) said that she provided a shower for Resident #33 on 1/9/24. After the shower, Staff C got the resident dressed while she was still in the chair, and she put gripper socks on her. Staff C said that she assisted the resident into the standing position to transfer her to the wheel chair, which was about two steps away, when the resident got weak, bent her knees and lowered to the floor. Staff C said that she assisted the resident with the transfer by grabbing the resident under her arm. She said that she had not put a gait belt on the resident. On 3/7/24 at 7:00 AM, Staff E, Registered Nurse (RN) remembered the fall that Resident #33 had in the shower room. She said that when the CNA came to get her, the resident was fully clothed, wearing gripper socks and sitting on the shower floor. The floor was wet, and the resident said that her wrist hurt. She said that while the resident was on the floor, Staff C applied the gait belt around the resident's waist at that time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/07/24 at 7:21 AM, the DON said that she had just learned that Staff C hadn't actually used a gait belt to transfer the resident from the shower chair to the wheel chair. She said that the CNA would be re-educated and disciplined. The DON said that her expectation was that staff would always use a gait belt when transferring residents. She said she would expect staff to tell her if there were any staff that were not using the gait belts. According to an undated facility educational checklist titled: Transferring Resident from Bed to Chair or Chair to Bed, staff were to position a gait belt around the resident's waist before assisting them to a standing position and with both hands under the gait belt while they transferred.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41785 Based on observation, interview, and record review the facility failed to ensure that staff used adequate infection control practices to decrease the transmission of pathogens for 2 of 14 residents reviewed (Resident #1 and #34). Resident #34 required daily dressing changes for several wounds and staff failed to use proper hand hygiene during cares. Resident #1 required staff assistance with incontinence cares, they failed to use adequate hand hygiene when changing the resident. The facility reported a census of 48 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated [DATE], Resident #34 had a Brief Interview for Mental Status (BIMS) score of 12 (moderate cognitive deficits). She was independent with rolling in bed and required supervision with transfers. Resident #34 had diagnoses that included urinary tract infections, renal insufficiency, and was at risk for developing pressure ulcers. The Care Plan updated on 2/24/24, showed that Resident #34 had the potential for pain/discomfort related to myalgia, multiple skin issues, and a history of skin yeast infection. The resident had a decline in functional ability, was unable to care for herself, and was at risk for impaired skin integrity related to fragile skin. She had unstageable pressure injuries on her bilateral heels, and a stage 3 ulcer on her spine. Staff were directed to keep her skin clean. On 3/04/24 at 10:33 AM, Resident #34 was in her bed on her back, she did not speak when addressed. A family member was in the room and said that the resident had just gotten out of the shower and was waiting for the nurse to come in and provide treatment to several wounds. With gloved hands, Staff A, Licensed Practical Nurse (LPN), applied betadine solution to the bilateral heels, wrapped the heals with a bandage, grabbed a marker and dated the dressing. She then applied a protective boot to the foot. Staff A failed to change her gloves. She then washed the right heel with saline solution, applied betadine to the right heel and wrapped it with a dressing. Without changing her gloves, she reached in her pocket for the marker, dated the bandage, and arrange the blankets on the bed without changing gloves. Staff A gathered trash and supplies and left the room without washing her hands. 2) According to the MDS dated [DATE], Resident #1 had a BIMS score of 9 (moderate cognitive deficits). She was at risk for developing pressure ulcers, but did not have any unhealed pressure ulcers at the time of the assessment. Diagnoses for Resident #1 included heart failure, anxiety disorder, schizophrenia, intellectual disabilities, and Down Syndrome. The Care Plan updated on 2/20/24, showed that Resident #1 had impaired decision making related to Down Syndrome and intellectual disabilities. She was at risk for pressure injury and impaired skin integrity due to incontinence of bladder and bowel. She required assistance with activities of daily living related to limited mobility. On 3/04/24 at 10:58 AM, Resident #1 said that she had a sore on her upper thigh that was causing her some pain, especially when she was sitting in the wheel chair. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/05/24 at 2:00 PM, Staff C, CNA and Staff D, CNA, moved Resident #1 to her bed and removed her brief. As they were checking her for skin issues, the resident said that she needed to use the bed pan. Staff D went to bathroom and got the bed pan, placed it under her and waited until she urinated. Staff D emptied the bed pan in the toilet and came back to the bed with a towel and a couple of wash cloths to clean her. With gloved hands, Staff D wiped the residents bottom several times. Staff C handed Staff D a 4x4 covering for an open sore on her upper thigh. With the same gloved hands, Staff C took a tube of barrier cream, squeezed some on the pad, spread it around on the 4x4, then applied the pad to the open sore. With the same gloved hands, Staff C then grabbed the blankets and pulled them over the resident. She gathered the trash that contained the soiled brief, grabbed the door knob, and exited the room with the trash with same gloved hands. On 3/06/24 at 3:13 PM, the Assistant Director of Nursing (ADON) and Infection Preventionist, said that she would expect staff to use hand hygiene, and glove changes whenever they were going from dirty to clean situations. She would expect them to wash their hands when entering and leaving a residents room. According to the facility policy titled: Infection Control Program, last reviewed 4/2/23, hand hygiene procedures would be followed by staff involved in direct resident contact.